**Non-Medical Prescribing Supplementary Information Form for employed NHS or Non-NHS Organisation or Partnership Applicants Only**

This form is to be completed in addition to your online application form by both you as the Applicant and your chosen Assessor and then the completed form should be uploaded with your application via the online portal.

We will be unable to progress with your application until this form is returned and fully completed. Any delays in returning this form will impact on the processing time of your application.

## Applicant details and employment information.

Full Name:

Job Title:

1. Length of time in current role which you will prescribe?
2. Is your role primarily ambulance-based?

Yes

Or

No

1. Describe your current role and specialist area of practice:

If you are Nurse (level 1), midwife, health visitor or school nurse, please provide the following information.

1. NMC registration no (You will be required to provide proof of your registration as part of the application process):
2. Number of FULL years of post-registration experience (min 1 year post reg):

If you are a Paramedic, chiropodist, podiatrist, radiographer, physiotherapist, please provide the following information.

1. HCPC registration number (You will be required to provide proof of your registration as part of the application process):
2. Number of FULL years of post-registration experience:
3. Have you ever applied for and commenced a programme of prescribing preparation before?

Yes

Or

No

## Funding

1. Are you being funded by your HEALTHCARE ORGANISATION? If YES, please provide details below:

Healthcare Organisation name:

Education Lead name:

OR

1. If you are NOT being funded by your HEALTHCARE ORGANISATION. Please state your source of funding for this course, e.g., SELF FUNDING or EMPLOYER SPONSOR:

## Student Declaration

Please answer YES or NO to confirm the following statements are correct:

1. I have the ability to study at the appropriate academic level (Degree level 6, or master’s level 7)?

Yes

Or

NO

1. I can demonstrate appropriate numeric skills (e.g., GCSE in mathematics, or Learn Direct level 2 numeracy)?

Yes

Or

No

1. I have identified a service need (in agreement with my employer) requiring me to undertake independent/supplementary prescribing training?

Yes

Or

No

1. I am able to provide evidence of assessed competence to take a history, undertake a clinical assessment, diagnose, plan, and evaluate care before accessing this course?

Yes

Or

No

1. I am willing to undertake another module concurrently to meet this requirement.

Yes

Or

No

IF NO: Please choose ONE of the following statements and enter details:

1: I am currently enrolled on a recognised, credit-bearing consultation/assessment/diagnostics skills module, or a condensed consultation and assessment non-credited course. Please tell us the course title, start date and education provider

2: I have already completed a recognised, credit bearing consultation/ assessment/ diagnostics skills module. Please tell us the course title, award date and awarding institution.

3: I have already completed a recognised condensed consultation and assessment non-credited course. Please tell us the course title, course date and education provider.

4: I can demonstrate, within my knowledge and skills framework, that I regularly undertake specialist assessments within my role:

Please answer YES or NO to confirm that your employer has given commitment to the following:

1. My attendance on this course:

Yes

Or

No

1. Provision of continuing professional development/updating:

Yes

Or

No

1. Provision of a Practice Assessor:

Yes

Or

No

1. Access to a prescribing budget and other necessary requirements for my prescribing practice:

Yes

Or

No

## CONFIRMATION OF ABILITY TO DIAGNOSE IN AREA OF SPECIALITY

TO BE COMPLETED BY YOUR EMPLOYER or IF SELF EMPLOYED TO CONFIRM STATEMENTS. Please complete in BLOCK CAPITALS:

* Applicant name:
* Applicant job title:
* Area of specialty:
* Name of Line Manager:
* Name of employing Organisation:

‘I confirm that the above-named applicant has been assessed as competent to take a history, undertake a clinical assessment and diagnose. I am aware that registrants should not be put forward for the Non-Medical Prescribing course if they have not demonstrated the ability to diagnose in their area of specialty\*.’

\*NMC guidance states “it should be possible to identify whether a registrant has these skills through Continuing Professional Development (CPD) reviews within the workplace setting”

Signature of Line Manager:

Date:

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### **DECLARATION OF GOOD HEALTH AND GOOD CHARACTER**

‘I declare that my health & good character is of a standard that enables me to deliver safe and effective practice’

Full name:

Signature:

Date:

### **DISCLOSURE AND BARRING SERVICES (DBS) CHECK**

To be completed by your employer:

‘I confirm that the applicant named above has undertaken a DBS check within their current employment in the last 3 years.’

\* If no, please attach copy of DBS application as evidence that this has been applied for

Full name:

Signature:

Date:

The above applicant will be asked to provide a copy of their up-to-date Enhanced DBS certificate (Child and Adult workforce) to the Admissions office as part of the application process. The certificate must have been issued within the last three years. We are also required to see all pages of the certificate, even if they are blank as we must see the full completed certificate. If they are unable to provide a copy of an Enhanced DBS certificate, they should contact the Admissions Office via email at [healthcpd@northampton.ac.uk](mailto:healthcpd@northampton.ac.uk) for further advice and additional information.

## PRACTICE SUPPORT

1. Has a Practice Assessor been identified?

Yes

Or

No

## Information on the requirements for the Practice Support Roles.

A minimum of 90 hours of supervised prescribing practice. The Practice Supervisor (s) and / or Practice Assessor have a crucial role, which includes:

* Establishing a learning contract with the student.
* Facilitating learning through critical thinking and reflection.
* Providing dedicated time and opportunities for the student to observe how the Practice Supervisor (s) / Practice Assessor conducts a consultation/ interviews the patient/ carer and develops a management plan.
* Allowing time for the student to carry out consultations and suggest clinical management plans and prescribing options which are discussed with the Practice Supervisor (s) / Practice Assessor.
* Allowing for the development and integration of theory and practice
* Giving opportunities for in-depth discussion and analysis of clinical management plans using random case studies where patient care and prescribing behaviours can be discussed further.
* Assessing and verifying that by the end of course the student is competent to take on the prescribing role.

If you are unable to access separate individuals to act as your Practice Assessor and Practice Supervisor, please contact the Programme Leader to discuss the reasons for this, and why it will be necessary for the Practice Supervisor and the Practice Assessor to be the same person.

Please answer YES or NO to confirm the identified Practice Assessor has:

1. Agreed to assess me on this course?

Yes

Or

No

1. Is a registered prescriber, with at least 3-year prescribing experience?

Yes

Or

No

1. Agreed not to assess more than 2 students on the NMP programme at any one time?

Yes

Or

No

1. Gained the approval of the employer to undertake this role?

Yes

Or

No

1. Agreed to undertake a short preparation if required for the Practice Assessor role, if they have not been a Practice Assessor for an independent/supplementary prescribing programme before?

Yes

Or

No

## SECTION A - To be completed by applicant:

I do not have any conflict of interest with my Practice Assessor

(You must let us know of any conflict of interest ‐ for example, if they are a relative or you are in a relationship with them other than a professional working relationship)

* Full name:
* Workplace contact details (Address, phone, email):
* Signature:
* Date:

## SECTION B - To be completed by Practice Assessor:

I have discussed the Practice Assessor role with the above candidate. I have the support of my employer to engage with this role and I agree to undertake the role and to access the preparation provided.

* Full name:
* Professional regulatory body:
* Professional registration no:
* Designation and professional qualifications:
* Workplace contact details (Address, phone, email):

Signature:

Date:

Once this form is completed, please upload all pages of the document to your online application portal for assessment by the Admissions office and Programme Leader, along with your full completed application. We will be unable to progress with your application until this form is returned and fully completed. Any delays in returning this form will impact on the processing time of your application.